State of Wisconsin Department of Workforce Development Equal Rights Division Civil Rights Bureau	**Retaliation Complaint** **Elder Abuse/Health Care Worker Laws**	ERD Case Number

Personal information you provide may be used for secondary purposes. [Privacy Law, Section 15.04(1)(m) Wisconsin Statutes.]

THESE RETALIATION LAWS ARE Sections 16.009, 46.90, 50.07 and 146.997, Wisconsin Statutes.
Each law has different retaliation protections. The Equal Rights Division will match your complaint with the laws. The division will notify you and the Respondent of the applicable laws. You will have an opportunity to inform the division if you disagree.

Instructions -- Please Read Before Completing This Form

- Provide all information requested below. **TYPE OR PRINT IN BLACK INK.**
- You must sign this complaint **on page 2,** and fill out the Process Information Sheet on **page 3** before submitting your complaint to the Equal Rights Division.

1. Complainant Information:	**2. Respondent Information:**
Your First Name Your Middle Name Your Last Name	Name of Respondent(s) (The company(s) or organization(s) you believe retaliated against you.) If there is more than one respondent, fill out this box with information about one Respondent. Use a separate sheet of paper to give the same information about the others and attach to this form.
Your Street Address	Respondent Street Address
Your City	Respondent City
Your State	Respondent State
Your Zip Code	Respondent Zip Code
Your Home Telephone Number (include area code): ( )	Respondent Telephone Number (include area code): ( )
Your Work Telephone Number (include area code): ( )	What type of business is the Respondent?
May we call you at work? ☐ Yes ☐ No	Describe the Respondent's residents/patients Age: ☐ Under 60 ☐ Over 60 ☐ Both Persons with Disabilities: ☐ Yes ☐ No Other:
County in Wisconsin where you worked:	

3. What did you do that you believe is protected by law? (For example: "complained about abuse or neglect of patients or residents", "reported understaffing", "objected to a standard of care issue" etc.) Give the date of each action (mo./day/year). If you did not do anything, skip to question #5.

NOTICE REQUIRED UNDER Section 15.04(1)(m), Wisconsin Statutes: Authorization for this form is provided under Section 111.39(1), Wisconsin Statutes. Completion of this form is voluntary. However, if you wish to file a complaint of retaliation with the Equal Rights Division (ERD), you must submit a written document containing the information sought by this form. This information is used for the purpose of processing your complaint and maintaining the Equal Rights Division's records.	For Office Use Only

4. If you answered question 3, did you talk, write or send an Email to someone? ☐ Yes ☐ No

If No, skip to question 5. If Yes,

- Give the name, title and telephone number of the person you contacted. (For example: "Jane Doe, state ombudsman," "John Forest, my supervisor," etc.)
- Give the date of each action.
- What exactly did you say?

5. If you did not answer question 3 or answered NO to question 4 :

- What action do you believe your employer thought you had taken or would take?
- Give approximate date when you believe your employer started thinking that.
- Give the name and title of the person who believed that. (For example: "Jane Doe, my supervisor", "Pat Meadow, the Director of Nursing", "Bill Maple, the Administrator", etc.)

6. Describe the employment action(s) your employer took because of what you did or because of what they thought you did or you would do. (For example: terminated me, disciplined me, demoted me, reduced my hours, etc.) If your employer took more than four employment actions, please describe on a separate sheet of paper and attach to this form.

a. First employment action:

Date taken:

b. Second employment action:

Date taken:

c. Third employment action:

Date taken:

d. Fourth employment action:

Date taken:

7. Certification And Signature

By my signature below, I certify that I have read the above complaint, and, under penalties of law, I declare that this complaint is true and correct to the best of my knowledge and belief.

Signature of complainant or authorized representative	**Date signed**

Mail Your Completed and Signed Complaint to One of The Following

State of Wisconsin
Department of Workforce Development
Equal Rights Division

201 E. Washington Ave., Room A300
PO Box 8928
Madison, WI 53708
Telephone: (608) 266-6860
FAX: (608) 267-4592
TTY: (608) 264-8752

819 North 6th Street
Room 255
Milwaukee, WI 53203
Telephone: (414) 227-4384
FAX: (414) 227-4084
TTY: (414) 227-4081

EQUAL RIGHTS COMPLAINT PROCESS INFORMATION SHEET

Please answer the following questions and return this sheet with your completed complaint. We need this information to effectively process your complaint.

First Name	Middle Name	Last Name

Today's Date	Your Date of Birth (requested for identification purposes) (Month/day/year)

If your job requires you to have a License or Certification (i.e. EMT, 1st Responder) please indicate what it is.
If not required, leave blank.

Availability/Contact Information

(Important! You must notify the Equal Rights Division if you change your address or telephone number. If we are unable to locate you, your complaint may be dismissed.)

Is there a telephone number where you can be reached between 7:45 a.m. and 4:30 p.m.?
☐ Yes ☐ No

If yes, provide the area code and number
( )

Please provide the name, address, and telephone number of a friend or relative who does not reside with you but who will know where you can be reached:

Name of contact person	Relationship to you

Address	Telephone Number ( )

Employer Information

Approximate number of employees at all work locations:
☐ Less than 15 ☐ 15-100 ☐ 101-200
☐ 201-500 ☐ More than 500

Does another company own the Respondent?
☐ Yes ☐ No ☐ Don't know

If yes, please provide the name of that company

Settlement Information

Complete this section if you were (or still are) employed by Respondent:

When were you hired?	What is/was your job title?

Are you still employed by the respondent?
☐ Yes ☐ No

Complete this section if you are no longer employed by the respondent:

How did your employment end?
☐ Discharged ☐ Quit ☐ Laid off ☐ Retired ☐ Other

The date your employment ended	Rate of pay at termination	Hours worked weekly

If you were not promoted, what was the title of the position you applied for?

Rate of pay	Hours per week

At this time, what are you seeking to settle your complaint?

You will have an opportunity to provide more information during the investigation

Statistical Information: Are you: ☐ Male ☐ Female

Race (check appropriate box or boxes):
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Unknown

National Origin or Ethnic background (check one):
☐ Hispanic or Latino
☐ Arab, Afghani or Middle Eastern
☐ Other